Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

NUEVA VIDA BEHAVORIAL HEALTH ASSOC
5555 FREDERICKSBURG RD, STE 102
SAN ANTONIO, TX 78229

Respondent Name
ACE AMERICAN INSURANCE CO

Carrier's Austin Representative Box
Box Number 15

MFDR Tracking Number
M4-12-2711-01

MFDR Date Received
APRIL 19, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The date of service being denied for payment is 8/3/11. This date of service was performed within the authorized timeframe and was denied in error…In this evaluation the following psychological tests were administered, and also recommended by ODG-TWC, Pain Patient Profile, BDI-Beck Depression Inventory, and McGill Pain Questionnaire. This was the first interview "

Amount in Dispute: $660.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We have escalated this request to our managed care vendor to verify the claim has been processed according to the Texas State Fee Schedule."

Response Submitted by: Gallagher Bassett Services, Inc., 6404 International Pkwy #2300, Plano, TX 75093

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 3, 2011	90801	$660.00	$241.65

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the guidelines for services requiring preauthorization.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits (Audit date not found on Explanations of Benefits)
   - 19 – (197) Precertification/Authorization/Notification absent.
   - 19 – (197) This line was included in the reconsideration of this previously reviewed bill.

Issues

1. Did the disputed services require preauthorization per Rule 134.600?
2. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.600(p)(7) states, "(p) – Non-emergency health care requiring preauthorization includes: … (7) all psychological testing and psychotherapy, repeat interviews, and biofeedback, except when any service is part of a preauthorized or division exempted return-to-work rehabilitation program." Review of the documentation finds that the disputed service is for an initial diagnostic interview. According to the requestors position statement this was the first interview. No documentation was found to support that the disputed service was a repeat diagnostic interview. Therefore, the requestor was not required to obtain preauthorization per 28 Texas Administrative Code §134.600(p) (7) .
2. In accordance with 28 Texas Administrative Code §134.600(p)(7) reimbursement is recommended as follows: CPT code 90801- 54.54 WC CF/33.9764 Medicare CF x 150.54 Participating amount = $241.65.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $241.65.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $241.65 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	1/7/2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.